From: Halpin, Susan [redacted]
Sent: Friday, November 29, 2013 5:12 PM
To: SIM, OHA
Cc: Stover, Keith; Halpin, Susan
Subject: Connecticut State Innovation Model: Comments on behalf of the Connecticut Association of Health Plans

TO: Victoria Veltri, Healthcare Advocate
sim@ct.gov

FROM: Connecticut Association of Health Plans - Keith Stover and Susan Halpin

DATE: November 29, 2013

RE: Connecticut State Innovation Model

On behalf of the Connecticut Association of Health Plans, we'd like to thank you for the opportunity to provide formal comment on the Connecticut Healthcare Innovation Plan (CHCIP) Draft 1.1. Connecticut's health insurance carriers support the state's goal of looking toward new integrated models of care delivery and practice transformation to enhance the health outcomes of Connecticut consumers through payment reform and quality improvement. As the formulation of this effort continues, we welcome a continued dialogue and hope to remain active participants in the planning discussion.

As you know from your ongoing conversations with our Association members, the commercial industry has not only embraced a value centered philosophy, but has acted upon it and has already made substantial investments in many of the accountable care organization and medical home concepts contained within the CHCIP draft. Health plans have direct experience in contributing resources to provider practices that have demonstrated a commitment to transforming into high value and efficient primary care settings that employ care teams and practice population management. As such, the carriers are very concerned about any initiative that might disrupt, intentionally or unintentionally, the reform efforts that are already underway and showing great promise. Toward that end, we appreciate the planning committee's continued verbal assurance that carrier participation will be voluntary moving forward and recognize that no insurance "mandate" provisions have been incorporated into the plan. However, ***we would respectfully request that the language of Draft 1.1 be modified to incorporate the underlying "voluntary" sentiment.***

As carriers engage in the health care reform debate, whether it be in D.C. or in the various states, they strive to adhere to two guiding principles 1) does the proposal duplicate existing efforts and 2) does it incorporate existing national standards. This is a particularly sensitive issue for those national payers that realize significantly increased administrative burden in dealing with states that employ vastly different regulatory standards and structures. In viewing the CHCIP through this lens, there are a couple of points of note that emerge as follows:

- With respect to data aggregation, carriers have been actively engaged with Connecticut's All Payer Claims Database (APCD) initiative which is being developed under the umbrella of the Health Insurance Exchange. Developing an effective APCD is a complex undertaking as it seeks to take disparate health

plan data and make it uniform for purposes of analysis. Providing different data feeds to additional provider and patient databases would be problematic. ***We would strongly encourage the CHCIP to partner with the APCD for any data analytic requirements envisioned under the plan.***

- Page 73 states that "The state anticipates that payers will expand or repurpose existing audit resources to support the recommendations of this council." Health plans currently adhere to National Committee for Quality Assurance (NCQA) standards which protect against both underutilization and overutilization of services by providers. Mechanisms are already in place to assure that underservice is not an issue and such mechanisms apply across provider types and payment models. ***Carriers would not support the repurposing of audit functions that are inconsistent with NCQA.***

- All carriers currently offer patient and provider portals. Through these portals providers can identify patient-specific gaps in care among other things. Given the national reach of many payers, it would not be cost effective to establish a separate Connecticut site for providers or members. Commercial members currently have access to highly secured sites for healthcare questions, disease management, claims issues, provider search and cost information. ***The draft report should encourage the commercial payers to continue these initiatives, while providing flexibility in their implementation and operation.***

Additionally, the Association would like to call attention to certain aspects of the plan that, we believe, need further discussion and development as follows:

COMMUNITY HEALTH IMPROVEMENT APPROACH (PAGE 51)

One strategy proposed in this component is the introduction of Health Enhancement Communities (HECs). We need to better understand what specific criteria will be used for selecting the targeted geographies and the enrollment process for patients. While we understand the desire to create community wide measures and incentive programs to avoid risk selection by providers, we are concerned with the potential duplication of incentives for patients in an existing shared savings program and a community based incentive program. In addition, carriers recognize and agree Community Health Improvement is an important element of the triple aim and with respect to the development of a metric would like participate in such discussions so that the specified metric aligns with any existing metrics already in place.

CARE EXPERIENCE SURVEYS (PAGE 61)

Patient experience surveys are important in the transformation to the medical home when given at the provider/practice level as a measure of the third arm of the triple aim, improved patient experience. To that end, it should be funded by the practice in the same manner as other quality initiatives which in this plan will be through the new valued-based payment models. Again, we recognize and agree consumer experience is important but we need to ensure we understand and agree on metrics, including the baseline for measurement.

The plan identifies different scenarios of clinical integration to attain scale and capabilities, pg. 47, for practices to adopt the capabilities needed to achieve Advanced Medical Home status. While we agree there are varying levels of clinical integration, further clarification on minimum standards is needed as well as the ability for payers to evaluate entities to ensure they meet the necessary standards for contracting and success under a Shared Savings Program

We believe that performance brings transformation. As the state has identified in the Connecticut Healthcare Innovation Plan, not all providers will be ready or able to be Advanced Medical Homes at the start of the program. We agree that those providers will require a "glide path" to transition to a higher level of accountability. However, funding to those providers should be provided as they transition based on achievement of pre-defined metrics as opposed to upfront investments. Practice transformation takes time. Providers need to

be rewarded based on their existing ability to impact cost and quality. We believe true success in reform is to not take an overly prescriptive approach but to involve a set of initiatives that strongly encourage providers to deliver high-quality care more efficiently, with an unspecified mix of strong performance incentives that reflect the market structure and capabilities of the local community. As providers achieve targeted goals new standards are set leading to transformation at a pace the provider is comfortable with and able to achieve verses expectation that funding will create change.

Health plans support financial incentive models which include pay for performance or shared savings, based off a practice's level of readiness that helps a provider transform. We need to understand the intention of allowing Glide Path providers to earn rewards in the first year based on quality performance alone, pg. 72. The transition from paying for volume and intensity to paying for value and outcomes — and the parallel changes required in care delivery — must involve measuring the quality, cost, and efficiency of health care. Shared savings is a derivative of reduced cost while quality targets are the gate for the provider to be eligible for shared savings. Glide Path providers may be more suited for a higher level of pay for performance verses modifying the shared savings program.

DATA AGGREGATION TO MEASURE PROVIDER PERFORMANCE (PAGE 73) AND COSTS

As stated above, the carriers are currently working with the Connecticut All Payer Claims Database (APCD) and strongly encourage the CHCIP to use the APCD to populate reports and portals for provider quality and cost measurement as well as for any HIT requirements. However we would like the opportunity to further discuss the concept of data aggregation for total cost of care and pay for performance.

RACIAL AND ETHNIC DATA

Additional discussion is needed as to the ability to collect and report on racial and ethnic data.

Thank you for the opportunity to review and comment on the Connecticut Healthcare Innovation Plan. The Association and its member carriers look forward to working with the state throughout this process and greatly appreciate the opportunity to continue a dialogue. Many thanks for your consideration.